

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B.P.A.)

00827

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County.....

Calvert

City or town.....

Huntingtown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Amine Gertrude Bowes Crawford

4. Sex

5. Color or race

Female white

6. (a) Single, married, widowed, or divorced

X

6. (b) Name of husband or wife.....

John L. Crawford

6. (c) If alive, give age..... years

1880 1870

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
77	2		hrs. min.

9. Birthplace.....

Parsons

(Town, county, and state)

10. Usual occupation.....

house wife

11. Industry or business

Agabus Bowes

FATHER

12. Name.....

Parsons

13. Birthplace.....

Gibson

MOTHER FATHER

14. Maiden name.....

Grace Gibson

15. Birthplace.....

Parsons

Grace Gibson

16. Informant.....

Address.....

Huntingtown

Burial

Date thereof.....

(month) (day) (year)

4 19 47

Cemetery or crematory.....

Calvary

Location.....

Huntingtown, Md.

18. Funeral director.....

Address.....

W. H. Hartman

Sevings, Md.

19. Date rec'd by registrar.....

April 19 1947

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Calvert

City or town.....

Huntingtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

16

April

19

47

at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 May

1944

to

16 April

1947

and that I last saw her alive on

16 April

1947

Immediate cause of death.....

Hypertensive Cardiovascular
disease

Due to.....

arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

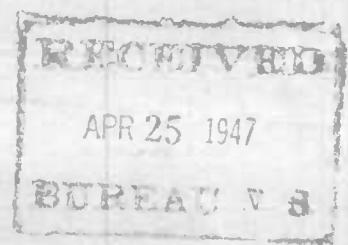
Means of injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. or other

Address..... Huntingtown, Md. Date signed..... April 19 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

008256

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

County..... Cabaret

City or town..... Port Republic

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elvise A. Hance

4. Sex F Color or race W 6.(a) Single, married, widowed, or divorced W

6.(b) Name of husband or wife Thomas C. Hance

7. Birth date of deceased (mo. day, yr.) May 29 1877

8. AGE: Years 69 Months 18 Days 25 If less than one day hrs. min.

9. Birthplace Cabaret Co., Md.

(Town, county, and state)

10. Usual occupation Home

11. Industry or business

Thomas W. Williams

MOTHER FATHER

12. Name Thomas W. Williams

13. Birthplace Cabaret Co., Md

14. Maiden name Elvise Ireland

15. Birthplace Cabaret Co., Md

16. Informant Mrs. Alexander Somervell

Address Port Republic, Md

17. Burial Date thereof Apr. 26, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Christ Church

Location Port Republic, Md

18. Funeral director O. G. Hackney & Son

Address Mutual, Md

19. 4-20-1947 N. W. Ward

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... 3rd

County..... Calvert

City or town..... Port Republic

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war..... No

3. (b) Social Security Number

220

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 24, 1947 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

19.....

and that I last saw h..... alive on..... 19.....

19.....

Immediate cause of death..... Coronary thrombosis

Due to..... Almost dead

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE Dr. J. L. Lallance M.D.

M. D. or other.....

Address..... St. Leonard, Md. Date signed..... Apr. 24



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is shown on

Evidence for the change of
age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

00828
#128

FILM NO. G 110 MAY 21 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County..... CALVERT

City or town..... SUNDERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... LIFE TIME

Hospital, Institution, or street address where death occurred: _____

How long in hospital or institution?.....

3. (a) FULL NAME

ELIZABETH

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD.

County..... CALVERT

City or town..... SUNDERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No._____

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

HAWKINS

4. Sex

F

5. Color or race

C

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife.....

JOSEPH F. MORSSELL

8.(c) If alive, give age..... 50? years

7. Birth date of deceased (mo., day, yr.)

MAY 18, 1888

8. AGE:

58

Years

154

Months

11

Days

20

If less than one day

hrs.

min.

9. Birthplace.....

MARYLAND
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name..... ROBERT HAWKINS

13. Birthplace..... CALVERT CO., MD.

14. Maiden name..... HANNAH

?

15. Birthplace..... CALVERT CO., MD.

16. Informant.....

JOSEPH LEROY MORSSELL

Address

SUNDERLAND, MD.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof..... May 18?

(month) (day) (year)

Cemetery or crematory

Location..... SOWER MAULBOW

18. Funeral director.....

Address

JARRY FUNERAL HOME

Address..... 101 FORMAN

19. (Date rec'd by registrar)

4/29 1947

W.H.Ward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

APRIL 28

1947 at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 1946 to April 23 1947

and that I last saw her alive on

April 23

1947

Immediate cause of death.....

Carcinoma of breast

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

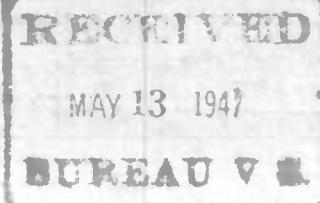
Page D. D. M.D.

M.D. or other

Address..... PRINCE FREDERICK, MD.

Date signed

4/29/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on G 109 4/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

00830/24

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County

Calvert

City or town

Adelina

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lawrence Henson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.

c

x

6. (b) Name of husband or wife

Myrtle Henson

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.)

July 7 1891

8. AGE:

Years
55

Months

Days

If less than one day

hrs. min.

9. Birthplace

MD

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER

FATHER

12. Name

Adenry Henson

13. Birthplace

MD

14. Maiden name

Rosia Curtis

15. Birthplace

MD

16. Informant

Myrtle Henson

Address

Adelina MD

17. Burial

Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Carroll's

Location

Calvert

18. Funeral director

P E Sewell

Address

Prince Frederick, MD

19. (Date rec'd by registrar)

4-3-47

A. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert

City or town Adelina (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

4-1-1947 at 4:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-1946 to 3-31 1947

and that I last saw him alive on 3-31 1947

Immediate cause of death Cardiac Failure DURATION

Due to hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please delineate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

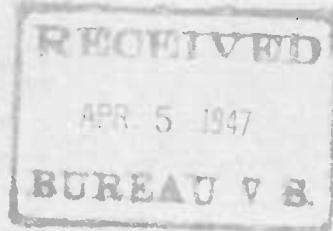
Means of injury

Injured at work?

23. SIGNATURE

Page 1st M. D. or other

Address Prince Frederick, MD Date signed 4-3-47



1-35

Evidence for addition of
usual residence of mother shown on:

FILM No. G 11 APR 28 MARYLAND STATE DEPARTMENT OF HEALTH

Birth & Death 00831
2000

Reg. Dist. No. 52

CERTIFICATE OF STILLBIRTH

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County

Calvert

City or town

Grace Federich

(If outside city or town limits, write RURAL and give nearest town)

Street, address, hospital, or institution:

Calvert Co. Hosp

Length of mother's stay in County

5 months

(How many years, or months, or days. SPECIFY WHICH)

3. Name of child

1st Bay Humphrey

4. Sex

Male

5. Twin or triplet

Twin

FATHER OF CHILD

8. Full name

Edward ever Humphrey

9. Color

W

10. Age at time of this birth

22 yrs.

11. Usual occupation

Electrician

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? None
(b) How many other children were born alive but are now dead? No
(c) How many other children were born dead? No

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of Died shortly
after birth about 1 hour

19. Labor: (a) Complications of None
(b) Induced?

20. (a) Was there an operation for delivery? No
(b) State all operations, if any

(c) Did child die before operation? No
During operation?

23. (a) Burial (b) Date thereof 4 17 47
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Harmony

24. (a) Funeral director W. H. Hutchins

(b) Address 2000, Md.

2. USUAL RESIDENCE OF MOTHER:

State Maryland

County Calvert

City or town North Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If RURAL give LOCATION)

4. Date of birth April 16 1947 Hour 7 pm M.

7. No. of weeks pregnancy 23 weeks

MOTHER OF CHILD

12. Full maiden name Louise J. Carter

13. Color W 14. Age at time of this birth 21 yrs.

15. Usual occupation Housewife

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Multiple pregnancy

(b) Maternal causes

22. I certify to the birth of this child who was born dead* on the date and hour above stated

Signature Grace D. Hutchins
(Specify if M. D., midwife, or other)

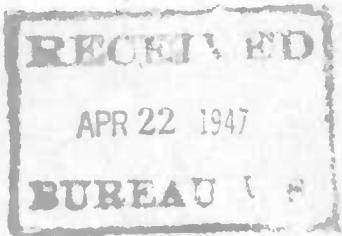
Address Grace Federich

25. (a) April 16, 1947 (b) Grace D. Hutchins
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

60832

5-2

Reg. Dist. No.

~~MARGIN RESERVED FOR BINDING~~
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
 is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County.....

Calvert

City or town.....

Rural, Ch. Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Ch. Beach

How long in hospital or institution?

3. (a) FULL NAME

Baby girl Hurley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

B

& single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 16, 1947

6. (c) If alive, give age.....years

8. AGE: Years

Months

Days

If less than one day

18

hrs

min.

9. Birthplace.....

Ch. Beach Calvert Co., Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name.....

C. Hayes Hurley

13. Birthplace

Sunbury, Md.

14. Maiden name.....

Mary Brown

15. Birthplace

Willow, Md.

16. Informant.....

Charles Hurley

Address

Willow Rd

17. (Burial, cremation, or removal, if any)

ST. Edmunds

Date thereof. April 18-47

(month) (day) (year)

Cemetery or cemetery

Location

Chesapeake Beach, Md.

Wilton Ward

Address

Chesapeake Beach, MD

18. Funeral director

Vigil P. Carpenter

Address

Huntington, Md.

19. H-17 1947

Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Calvert

City or town.....

Rural Ch. Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Ch. Beach

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

17 April

1947 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

16 April

1947

to 17 April 1947

and that I last saw her.....alive on 16 April 1947

Immediate cause of death.....

Premature birth

DURATION

Age 18 hours, Gest. 38 weeks

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

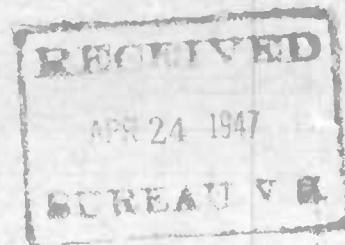
Helen Carpenter

M. D. or other

Address.....

Huntington, Md.

Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

00833 125

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Calvert

City or town.....

Susby

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Martha D Janey.

4. Sex

F

5. Color or race

C

6.(a) Single, married, widowed, or divorced

X

6.(b) Name of husband or wife.....

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 7 1873

8. AGE:

74

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Md

(Town, county, and state)

10. Usual occupation.....

Domestic

11. Industry or business

MOTHER FATHER

12. Name.....

John H. Johnson.

13. Birthplace.....

Md

14. Maiden name.....

T

15. Birthplace.....

16. Informant.....

Annie Johnson

Address.....

Susby Md.

17. Burial

(Burial, cremation, or removal Which?)

Date thereof..... 4-10-47
(month) (day) (year)

Cemetery or crematory.....

White Hall

Location.....

Calvert.

18. Funeral director.....

P. E. Sewell

Address.....

Prince Frederick,

19. (Date rec'd by registrar)

4-9

19 47

H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Calvert

City or town..... Susby

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 4-7, 1947, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

at 19 47 to 19 47

and that I last saw h. s. alive on 4/7/47 19 47

Immediate cause of death.....

Cerebral artery Disease

DURATION

Due to..... Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

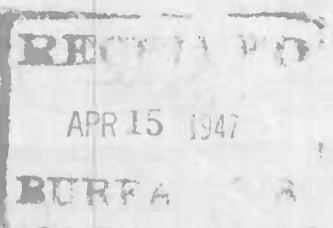
23. SIGNATURE.....

M. D. or other

Address.....

Page 2 of 2

Date signed 4/9/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

048327

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County.....

Calvert

City or town.....

Calvert County Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Christopher C Kyle

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 1866

6. (c) If alive, give age..... years

8. AGE:

Years
87

Months

Days

If less than one day
....hrs.min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

MOTHER FATHER

12. Name..... James Kyle

13. Birthplace

Va

14. Maiden name..... Sarah Furnash

15. Birthplace

Va

16. Informant.....

Bernard Kyle

Address

N. Beaufort Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof. Apr. 22 1947

(month) (day) (year)

Cemetery or crematory.....

Mt. Olivet

Location.....

Bladensburg, D.C., Wash. D.C.

18. Funeral director.....

Wm. J. Kelly

Address

522-8-118, S. Wash. St. b.

19. 4/20 1947

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Calvert

City or town.....

N. Beaufort

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 April

1947, at 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 May 1946 to 19 April 1947

and that I last saw h. m. alive on 19 April 1947

Immediate cause of death.....

arterio-sclerotic heart disease

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Huntingtown Md

Date signed 24 April 1947



Mr. John D. French